



11 Fairfield Boulevard, Wallingford, CT 06492
800-440-5071 Fax (203) 265-3994 www.chnct.org

CHNCT HOME CARE INTAKE FORM

Member's Name: _____ Date of Birth: _____

Member's ID#: Plan: Husky: _____ Charter Oak: _____

Contact Name: _____ Home Care Agency: _____

Phone: _____ Fax: _____

Ordering MD: _____

Please print the ordering physician's FULL name and address *clearly* as we *cannot* process your request without this important information!

Date of initial visit: _____ Diagnosis/code: _____

Services requested: _____ Frequency/Duration/Date Range: _____

Skilled Nursing _____ (visits/wk)

Home Health Aide _____ (hrs/day/wk)

OT _____ (vts/wk) PT _____ (vts/wk) ST _____ (vts/wk)

Date of MD follow up: _____

For wound care please specify size: Width: _____ Depth: _____ Length: _____

Treatment requested: _____

Please Include Updated Clinical Notes and 485 Form With This Request.

Clinical notes must be faxed to CHNCT for review
Please fax request to 203-265-3994. Thank You

****PLEASE ALLOW 2 BUSINESS DAYS FROM RECEIPT OF ALL CLINICAL INFORMATION TO PROCESS REQUEST****